ACCESS

Newsletter of the Nebraska Office of Rural Health, Nebraska Health and Human Services System and the Nebraska Rural Health Association for all rural health stakeholders

Issue 43, February 2006

Nearly A Half-Million-Dollar Payoff from Telehealth -- So Far

By Dave Howe

Time is money. And Nebraska's Statewide Telehealth Network is paying off already in saved travel time to the tune of more than a $267,000 in less than a year's time.

Add the savings in mileage at the Federal IRS rate, and you can tack on another $232,000 to the benefit, for a total of $499,000 saved by the Nebraska Statewide Telehealth Network (NSTN) between January and November 2005.

That 11-month period is the first snapshot of ongoing data collection to quantify how much the NSTN is saving several Nebraska hospitals and their affiliates.

Using a conservative labor value of $25/hour, BryanLGH-Lincoln and its affiliates saved $85,800 in travel time during January to November 2005 by using the telehealth network. During that period, the savings for several other hub hospitals and their affiliated rural hospitals were as follows: St. Elizabeth Regional Medical Center in Lincoln, $84,000; Faith Regional Medical Center at Norfolk, $48,800; and Good Samaritan Health Systems at Kearney, $32,800.

St. Francis Hospital at Hastings and Central Nebraska Early Childhood, whose reporting didn't begin until July, realized a travel-time savings of $15,300 between them. Add it all up and the total

Continued on page 2

also in this issue . . .

EMS Services Going Electronic

Duties for emergency medical services (EMS) personnel don't end when they treat and transport a patient after an accident or medical emergency. But now the follow-up documentation EMS providers are required to do has gone electronic.

EMS personnel are required by state statute to document care given to a patient, and that includes recording approximately two dozen different items. Rules and regulations also require the state EMS program to provide a "form" for documentation purposes.

The "form," commonly known as the "NARSIS" (Nebraska Ambulance Rescue Service Information System) form, had been primarily on paper. But in fall 2004, the EMS program introduced "e-NARSIS" (electronic NARSIS), in an effort to bring the process of patient care documentation into the 21st century.

"Paperwork is steadily giving way to electronics," said Carla Becker, health data manager in the Data Management Section of the Nebraska Health and Human Services System (HHSS).

Doug Fuller, emergency medical services specialist in HHSS, and Becker emphasized that the EMS electronic information system and its accompanying modules didn't just pop up out of nowhere and fall into place without a lot of planning, foresight, and cooperation.

Coincidentally, the EMS data team was holding its initial meeting to begin creating e-NARSIS as the catastrophic events of Sept. 11, 2001, were occurring, Fuller said. During the group's discussions, the EMS Program introduced Dr. Don Rice, M.D., as a medical informatics specialist. Dr. Rice also is an emergency room physician and emergency medical services physician medical director.

During the following two-and-a-half years, the EMS Program continued to search for a funding source for the e-NARSIS product.

In spring 2004, Dr. Rice was given the go-ahead to begin developing the electronic information system, which included writing the RFP

Continued on page 3

Telehealth *cont'd from p. 1*

for those institutions comes to nearly $267,000. That's the value of travel time saved by interactive video conferencing over the NSTN for administrative personnel, physicians, and nurses.

Then, tack on the $232,000 savings in mileage at the Federal IRS rate, and you wind up with the nearly half-million-dollar benefit from the NSTN in the 11-month January to November 2005 period, as noted at the outset of this article.

Donna Hammack, chief development officer at the Saint Elizabeth Foundation, and the Foundation have volunteered to collect and compile the above figures for the NSTN, a role that may eventually fall to a yet-to-be established governing body responsible for overall management of the NSTN.

Rural hospitals affiliated with hub hospitals such as BryanLGH-Lincoln, St. Elizabeth Regional Medical Center, Faith Regional Medical Center, and Good Samaritan Health Systems send their data to their respective hub hospitals. The hub hospitals, in turn, compile the data in spreadsheet form and forward it to the Saint Elizabeth Foundation, where Hammack consolidates the information into summaries such as you're reading here.

"There's still more activity (on the NSTN) taking place than what we are actually quantifying," Hammack said. Not all institutions that participate in the NSTN are reporting estimated savings from their use of the NSTN. So the aforementioned 11-month totals don't reflect the Network's entire payoff. Nor do the aforementioned savings include time and mileage the network has already saved rural patients through consults over the NSTN with specialists or other healthcare providers who are not available closer to home.

And Hammack said a number of consults are being done over the NSTN.

For example, surveys show 51 consults over the NSTN for patients at rural hospitals affiliated with Good Samaritan Health Systems at Kearney, a hub hospital, in July and August of 2005. Those consults (numbers in parentheses) include: cardiology (3), clinical social worker (7), dietitian (2), endocrine (1), eye, nose and throat (2), psychology (3), neurology (3), orthopedics (12), speech pathology (1), wound care (1), diabetes (4), genetics (2), mental health (7), and psychiatry (3).

Nebraska Telehealth Network Web Site

The Nebraska Telehealth Network has created a pilot Web site for users and interested parties. The draft Web site is located at **http://www.frhs.org/Telehealth/main.htm**. This is temporary while we finish developing it.

Please look at the site and give Kim Robinette any ideas you have for advancing it to the next stage. It will be reviewed by the Telehealth Education Committee and after approval it will be posted as soon as time permits. Kim can be reached by e-mail at krobinette@frhs.org

In a survey of 51 patients represented in those consults with specialists over the NSTN, 23 answered that they would not have made the road trip to see the specialist. Twenty-five of the 51 patients said they would be willing to rely on telehealth again for healthcare from specialists.

A survey of patients at rural hospitals affiliated with BryanLGH in Lincoln tells a similar story: 20 consults involving endocrinology, 19 of whom said they would use telehealth again. However, 19 of the 20 said they would have traveled to see the specialist in the absence of telehealth.

And how about from the caregiver side?

On a scale of 1-7, from least to most effective, specialists gave ratings that averaged from 5 to 6.96 for how the system worked, 6 to 6.94 for their confidence in the NSTN, and 6.25 to 6.96 for their willingness to use the network in the future.

Behind all of these numbers is a story of vision, partnership, and cooperation among dozens of individuals, companies, and organizations, including these: healthcare associations, the state's legislative and executive branches, Nebraska's congressional delegation, University of Nebraska Medical Center and Creighton University Hospital, public health labs, public health departments, Nebraska Health and Human Services System (NHHSS), Nebraska Information Technology Commission, Federal Communications Commission, the Universal Services Administrative Company, Nebraska Public Service Commission, communications companies, and nearly 90 Nebraska hospitals.

Where did it all begin?

Dave Glover, hired by the Nebraska Hospital Association a couple of years ago to facilitate development of the NSTN, said that some of the early impetus for the concept began with ideas "from folks like Denny Berens (director of the Office of Rural Health at the Nebraska HHSS) and the Nebraska Hospital Association looking at the possibilities for such a network.

"They were capitalizing and leveraging the activities of existing networks such as the University of Nebraska Medical Center, Good Samaritan Health Systems, BryanLGH Medical Center, and others," Glover said.

Actually, you could trace

Continued on page 4

EMS *cont'd from p. 1*

(Request for Product) for bids from vendors. His background makes him particularly qualified for this role, Fuller and Becker said. His combined knowledge of hardware, software, and medicine "brings a wealth of medical history and talent that we can tap into," Fuller said.

During the ensuing months in 2004, the program received responses from vendors across the country. A committee of HHSS staff and private advisers evaluated and scored the bids and recommended to the HHSS administration that ImageTrend be awarded the bid.

This new electronic data collection system was purchased through the Statewide Trauma Program. This program is funded via the "Fifty Cents for Life" assessment, which is included on most motor vehicle registration fees.

The contract was awarded to ImageTrend in July 2004, at which time they began customizing the product for an October 2004 release, Fuller said. "We then asked EMS services of different sizes to test ImageTrend's product."

The electronic information system built by ImageTrend is an Internet based system. It consists of a master control program called the "State Bridge" and three other components, any of which may be used by emergency medical services to input patient care data. These components are the service bridge, the field bridge, and a module that allows services that own third party software to export their data into e-NARSIS.

Once patient care information is collected by EMS providers, it is sent via an encrypted Internet connection to a database maintained by ImageTrend, Inc., in Minneapolis, Minn. Full access to patient care information is restricted to the receiving health care facility, the EMS provider and authorized state personnel, Fuller said.

As mentioned earlier, patient care information may be submitted to e-NARSIS via three routes. The first of these is the "service bridge," which allows an EMS service to submit data by means of a desk top computer. The system best transmits through the Internet via a password-protected high-speed data line to www.nebems.com, Becker said. This method allows EMS services to utilize e-NARSIS without the purchase of a software license.

The second method of inputting into e-NARSIS is the "field bridge." An EMS provider can do patient care documentation at the patient's side by inputting data into a portable computer, such as a "ruggedized" tablet PC or laptop. "The EMS service is responsible for buying its own laptop that's capable of taking the hard knocks that you'd expect under field conditions," Fuller said. When the EMS provider completes its documentation it "posts" the data to the Internet, either wirelessly or through a hard-wired connection.

The "field bridge" system requires an ImageTrend software license that entitles an EMS service to access the Minnesota database. Thus far, the EMS Program has purchased approximately 140 licenses, which are issued on a first come-first served basis at no charge to an EMS service.

ImageTrend has built a third method of transmitting patient care data into e-NARSIS. Data collected through a third party software may be exported into e-NARSIS. This method is called "data export," Becker said. No license is required for this method; however, a service may need to purchase additional software from its vendor in order to be compatible with e-NARSIS.

No matter which method a service chooses to use to enter data into e-NARSIS, a two-day training session is required. To date, nearly half of the 430 registered users have attended training. Once the training is successfully completed, a service is issued its password to access and operate e-NARSIS. The service representative who attended training returns home to teach his or her fellow service members.

During the training, the services are shown the various aspects of e-NARSIS. These aspects include patient care data entry, the "frequent flier" capabilities of the field bridge, digital medical library called the "knowledgebase," the hospital bed tracking module, training records management, health alert network, syndromic disease surveillance, the ability to create a service Web site, a document file for protocols, and an internal messaging system.

An aspect of the e-NARSIS system that regularly captures the attention of services is the "frequent flier" feature. This feature allows for the immediate recall of specific patient information in cases where EMS providers repeatedly respond to patients with chronic health conditions. Fuller said, "Pertinent information collected before (in any previous call) is right there, eliminating the need for re-entry of all of this data," such as the address, medications and insurance information.

The saved time, particularly in volunteer systems, is of great interest to employers whose employees serve on an EMS

Continued on page 5

Telehealth *Cont'd from p. 2*

telehealth back to the late 1950s and a telehealth project that linked Omaha and Hastings, Berens said. It involved Nebraska Educational Television (NET) and education through both the University of Nebraska and Creighton University and healthcare providers, he added.

In the early 1990s, Hammack received an Office for the Advancement of Telehealth (OAT) grant, through which a telehealth model was formed, Berens said. "The Office of Rural Health created committees over the years to connect healthcare and communication providers to dream about the future," Berens said. Those committees played a key role in understanding the language and direction that telehealth was taking. They merged into the NITC (Nebraska Information Technology Commission) Telehealth Committee but maintained a separate Nebraska Telehealth Committee through which the telehealth Backbone model was created, Berens said.

Then the Nebraska Hospital Association took up the challenge to find the resources and personnel to move the project through its first formal stages.

The NITC Telehealth Committee is continuing to envision the broader issues that now need to be addressed and to create the partnerships necessary to bring this about, Berens said.

Glover said some of the key junctures in developing the network include these:

- An initial push from individuals and organizations, including support from the Nebraska Hospital Association.
- Support from the State of Nebraska, administratively and philosophically, through all levels, including the governor and lieutenant governor.
- Decision by the State of Nebraska to use Homeland Se-

Continued on page 6

Rural Health Association is on the Move!

By John Roberts

Maintaining health care service in America's rural communities has proven to be a tremendous challenge as rural communities struggle to preserve their local health care delivery systems.

The problems faced by rural health care include economic changes, which can devastate the local health system. Consider, for instance, the impact of population shifts on once-thriving agriculture, fishing, mining, or timber towns.

In other cases, rural communities have a high percentage of elderly and poor residents who depend heavily on government programs like Medicare and Medicaid. Some communities have too small a tax base to provide adequate public support for health care facilities and cannot generate enough revenues to operate a modern health care system. Still others struggle with the deficiencies and challenges inherent in the American health care system, from problems of the uninsured to fundamental disagreements over whether health care is a private or public good.

Despite these challenges, health care systems in most Nebraska communities have been surprisingly resilient. Very few of our rural hospitals have closed over the past decade. Some communities find themselves with fewer physicians or other practitioners to provide for the needs of their people. But, in most cases, health services for rural Nebraska remain in place.

A number of factors have contributed to this staying power, starting with the commitment of local leaders, bolstered by public and private subsidies directed to preserving access to health care in remote areas.

Still, many rural communities look to the future of their health system with a wary eye. The problems seem large, and the solutions fairly limited. While important efforts are under way, sponsored by government and other organizations, most are short or intermediate term responses.

Planning for the Future:

Helping to assure the ongoing viability of rural health care is essential to the Nebraska Rural Health Association's mission of improved health for the people of Nebraska. That is why NeRHA has put an aggressive strategic plan in place to meet these tremendous challenges.

Members of the NeRHA board of directors gathered at the Timberlake Ranch Camp on Nov. 4, 2005, to discuss plans for the organization's growth and development and to review the current mission and vision statement.

Participants included Marty Fattig, Julie Smith, Phyllis Gardner, Dave Palm, Joleen Huneke, Kathy Nordby, Alan Van Driel, Carly Runestad, and John Rainey. The session was facilitated by Robert Bartee from the University of Nebraska Medical Center.

The vision of NeRHA is: to be the leading advocate of equitable access to improved health status for rural Nebraska.

The NeRHA mission translates our vision into something. It guides our everyday efforts and is the touchstone for our decision making. The mission of NeRHA is: to bring together diverse interests and provide a unified voice to promote and enhance the quality of rural health through leadership, advocacy, coalition building, education and communications.

November's strategic planning process produced five strategic directions, all developed to achieve the best results for the Nebraska Rural

Continued on page 5

Rural Health *cont'd from p. 4*

Health Association and the membership it serves:

1. Establish political clout so that NeRHA is recognized as the "go to" organization on rural health issues.
2. Enhance the image and visibility of NeRHA as the leading source of information on rural health issues in Nebraska.
3. Expand educational offerings and improve participation at the annual rural health conference.
4. Increase the size and diversity of the NeRHA membership and increase the participation of the NeRHA membership in the association.
5. Hire a full time executive director by 2007.

NeRHA values its role in improving rural health care services and positively affecting the public health of rural people and communities. Through the involvement of its members, other organizations, and governmental entities, assistance is provided in achieving a more positive health care environment and maximum health status for all rural Americans. To this end, the NeRHA strives through this strategic plan to be a proactive and positive force in its efforts toward providing the best rural health care possible.

Few, if any, organizations are comparable to NeRHA. No other group has NeRHA's diversity, bringing a variety of interests together for a common cause — to strengthen rural health care for rural residents. When one considers the many issues and problems and the association's limited resources, the task seems mind boggling. Yet, I think you will agree with me that the activities we are engaged in show that we are working to make a difference. □

Critical Access Hospital: Performance/ Quality Improvement projects

By Dave Palm

Quality of health care services provided by Nebraska's Critical Access Hospitals continues to benefit from FLEX grants in a variety of ways.

The Office of Rural Health has received the Medicare Rural Health Flexibility Grant from the Federal Office of Rural Health Policy since 1999. One of the goals of the "FLEX" grant program is to improve the performance and quality of health care services in critical access hospitals (CAHs). This article briefly summarizes the major CAH performance improvement initiatives that are completely or partially funded under this grant program.

Application of the Balanced Scorecard

In 2004, Nebraska began to build statewide capacity to develop Balanced Scorecards in CAHs. The Balanced Scorecard is a useful tool for small rural hospitals because it aligns and links together key strategic initiatives and uses several indicators to monitor their performance in the four main categories: financial, Customer satisfaction, internal processes *(e.g.,* admission policies) and workforce development.

By tracking these performance measures, CAHs can identify major problem areas such as low patient satisfaction or high turnover of nurs-

Continued on page 9

EMS *cont'd from p. 3*

service. "It means those volunteers can be back at work a little sooner after a call," Fuller added.

The emergency medical services community is not the sole beneficiary of the e-NARSIS system. Among the other special features is a hospital bed tracking module. This feature, soon to be implemented, allows central reporting of the number and type of hospital beds available in the event of a major disaster that overwhelms hospital facilities at any particular location. "How they wish they would have had that in New Orleans, with thousands of patients to move but no idea of where to move them," Fuller said, in reference to the aftermath of 2005's Hurricane Katrina.

Yet another potential benefit of e-NARSIS is to serve as an early warning system. For example, the state epidemiologist may be receiving information from various locations. When all that information is fed into the database, unusual patterns of symptoms or conditions could be detected as an early warning.

The goals of the EMS Program for 2006 include having all Nebraska hospitals fully prepared to access e-NARSIS. The Nebraska Statewide Telehealth Network will make it possible for the trainer in one location to train staff at a half dozen or more hospitals at a time, eliminating the travel cost and time that on-site training sessions would require. "We don't want to make 70 presentations. If we can do 10 presentations at a time (through the telehealth network), that's a lot better," Fuller said.

More and more EMS services and hospitals are in the process of preparing to make the switch from paper to electronic records, Becker said. The EMS program believes it is successfully bringing a part of 21st century technology into the lives of Nebraskans.

For further information on e-NARSIS training, licenses and use, contact Carla Becker at (800) 422-3460, Ext. 34. □

Telehealth *Cont'd from p. 4*

curity funding to place equipment within hospitals.
- A decision by the Nebraska Public Service Commission to support the funding needs of the NSTN.
- Flexibility by the Universal Services Administrative Company for the project.
- Various points of agreement by hospitals on different aspects of working together.

Each of the above points represents a critical milestone. For instance, the network requires high-speed data lines that can cost anywhere from $400 a month to about $8,000 a month, which exceeds the tight budgets of Nebraska's rural hospitals.

The Nebraska Hospital Association, a group of telehealth partners and the telephone industry prepared and presented a proposal to the Nebraska Public Service Commission (PSC), seeking approval of a subsidy to buy down the cost of those high-speed lines.

Support from the Federal Universal Service Fund subsidy and the Nebraska Public Service Commission were combined to bring the monthly cost of a high-speed line for rural hospitals to about $100 per month.

High-speed connections such as T1 lines have a capacity of 1.5 million bits of data per second, and fiber optic lines can carry "nearly immeasurable amounts of data," says Rick Golden, director of the networks and systems computing services at the University of Nebraska.

Just three years ago, a majority of the state's rural hospitals didn't have these high-speed connections, which are required for such tasks as interactive video conferencing and moving radiological reports back and forth among healthcare and educational institutions.

But those lines are only the electronic "highways" to carry the data-intensive healthcare/health education traffic back and forth across the state. Hospitals still need the "vehicles" to travel those cyber roads: a bewildering array of switches, routers, poly coms, computers, and software to connect with each other.

Nebraska's 80 to 90 hospitals sat at various levels of understanding and technology to create a nerve trunk or "backbone" along which the data can flow back and forth simultaneously among hospitals, labs, and other institutions using the NSTN. That posed a number of technological challenges to making the NSTN a reality. "It was -- and maybe still is -- a work of 80-plus hospitals with different levels of understanding and levels of technology," Golden said. For example, some hospitals had "full-blown networks, while the next hospital had (only) two PCs," he said.

Getting the technologies to work together, including compatibility of software and firewalls for network security that meet HIPAA privacy requirements, is being done. "But all it takes is for one person (network organization) to update software, which has potential to throw a wrench in it," Golden said.

Bringing it all together into a workable whole requires a closely cooperating partnership among the 80-plus locations in the network, Golden said. Ultimately, that responsibility can be addressed by establishment of an organizational structure that can provide common management or oversight to the NSTN, he added.

Consultant Glover said that whatever organizational structure is chosen, it will need the flexibility to change as the NSTN and technologies change. Choosing a business model to provide that oversight is part of Phase II of the NSTN. The NSTN Advisory Council has already decided the business model should be a not-for-profit organization, such as a quazi-governmental 501c (tax-exempt) organization.

As he noted in the October 2005 ACCESS newsletter, the choice of business model will have an impact on the NSTN's role not only in healthcare but also in homeland security and educational services and as a network gateway to institutions such as the Centers for Disease Control and Prevention in Altanta, Ga., or prominent healthcare institutions like the Mayo Clinic and Johns Hopkins University.

Developing a system for sharing electronic patient health records among a patient's various sources of healthcare to prevent conflicting or redundant treatments may also have implications for the telehealth network.

Some of the software hurdles that remain to be cleared are what Golden calls "QOS" or quality of service issues. That includes who gets to decide how much of the available bandwidth at a hospital, for instance, is allocated to video conferencing and how much for a patient-specialist consult—maybe even during surgery. A video session, for example, may occupy one-third of the hospital's bandwidth or line capacity

More decisions remain concerning firewalls and encryption, especially as more entities join the network and add to its complexity, Golden said.

Details remain to be worked out as to who will maintain and repair network equipment. Hub hospitals hire information technology personnel to handle problems at their affiliated hospitals. "Some hubs are more committed than others" to that role, Golden said.

There is a lot of cooperative spirit among NSTN entities, especially on the part of hub hospitals, Golden said. "I can't say it enough." □

Helping Rural Nebraskans

Marilyn Mecham, IMN

In the early 1980's, financial pressure and related legal and emotional stress reached a crisis stage for many Nebraska farm families. As land values plummeted, debt piled, and foreclosures reached a record high, Interchurch Ministries of Nebraska (IMN) took action. In April 1984, IMN began forming a coalition, not only of its member church denominations, but also of agencies and organizations with a direct interest in confronting rural hardship.

Representatives of the coalition realized from the beginning that the underlying problems leading to the crisis would not be solved overnight, nor would the groups be able to provide money to troubled farmers. But they knew they could garner the human and financial resources to help provide sound financial and legal counsel when requested, and to respond to families with needs for emotional and spiritual support.

The plan grew quickly, because of the nature of the problem and the coalition's commitment to service. The leaders of Nebraska Christian denominations, Nebraska Department of Agriculture, Nebraska Farmers Union, WIFE, NFO, the Agriculture Extension Division of the University of Nebraska, Legal Aid Society, and lenders worked closely to build the response network and make it available to anyone in Nebraska agriculture.

Through the years the rural economic situation continued to take a toll on farmers and ranchers. The Rural Response Hotline (800/464-0258) became a lifeline for many individuals and families. One of the strengths of the Hotline is the immediate, direct response to identified needs. The Hotline staff spends time listening to each caller to find out personal issues and needs. The staff then offers the help of attorneys, financial advisers, professional counselors, mediators, clergy, and other people who have volunteered their expertise to the program.

As the number of calls increased, the need for mental health services became apparent. With the support of the Nebraska Health and Human Services and the Nebraska Office of Rural Health, the Counseling, Outreach, and Mental Health Therapy Project (COMHT) evolved. Callers to

Continued on page 10

Area hospitals respond enthusiastically to new service

Reprinted from Central Nebraska AHEC News, Volume 6, Issue 3, December 2005.

During the past several months, Central Nebraska AHEC has worked hard in the implementation phase of its Video Medical Interpreting (VMI) service, which provides interpretation capabilities to local hospitals through videoconferencing technology.

It has been a long and arduous job that is now showing positive results.

The hospitals that are using this service now can guarantee bilingual service to their patients 24 hours a day.

The last three months have shown an exponential increase in the level of usage of the service. Usage rates have increased 323 percent in August, 232 percent in September, and 145 percent in October.

Clinics and hospitals in Hastings, Grand Island, Aurora, Columbus, and Kearney are showing more and more interest in this new alternative to provide medical interpretation service in a convenient, efficient and economical fashion for the participating health care organizations and their clientele.

This explosive growth has allowed the project to get closer to its sustainability point, a goal that is highly desired since it will guarantee the long-term continuation of the program. Originally the VMI service was funded by a Robert Wood Johnson Foundation grant, but those monies will not be available in the future.

Recent statistics show that during the last few months, another important objective ahs been achieved. There is now a more even distribution of hospitals requesting interpreting service from VMI.

Hastings Community Health Center (HCHC) and Mary Lanning Memorial Hospital are the highest volume users of the service while a month earlier, the HCHC was the only institution to be identified as a main user.

This aspect is important because it allows the program to have a bigger impact in the society.

The consolidation of the VMI program as a project that is self sustained and, at the same time, ahs the capability to serve larger part of the population, is now becoming a reality, and that is certainly a good reason to celebrate.

For more information, contact: Sarah Cunningham at sara@cn-ahec.org □

Scholars selected for 2005-2006 Great Plains Public Health Leadership Institute;

institute further prepares Nebraska in promoting, protecting, advocating for public health

By Vicky Cerino , University of Nebraska Medical Center Public Affairs

Fourteen Nebraskans have been selected as the first class of scholars of the Great Plains Public Health Leadership Institute, a year-long program designed to strengthen leadership among those who work in public health.

Magda Peck, Sc.D., director of the Institute and University of Nebraska Medical Center professor of pediatrics and associate chair for community health, said Nebraska is experiencing unprecedented growth in public health.

"Nebraska and its neighboring Great Plains states need skilled public health leaders who will champion the mission of public health – creating conditions in which all people can be healthy," Dr. Peck said. "New state investments in Nebraska have helped establish local public health agencies statewide which cover every county.

"The new UNMC and University of Nebraska at Omaha graduate program in public health has over 100 students and 25 graduates. Continuing education and training for emergency preparedness are making sure we know how to be safe and sound when disaster strikes. What comes next is greater leadership for the public's health," she said.

The Institute is designed for senior and emerging leaders in organizations whose primary mission is to improve the health and well-being of populations and communities. Scholars may come from multiple states. The program includes three on-site sessions, monthly distance education, and an applied project for integrated learning.

The goals of the Institute, which is in its first year, are to: assure and enhance leadership knowledge, skills, attitudes, and competencies in the public health workforce of the Great Plains region, increase the value of public health within communities through greater leadership in action and expand relationships among public health leaders in the region.

The first group Great Plains Public Health Leadership Institute scholars in the class of 2005-2006 are:

Chad Abresch, CityMatCH, Omaha
Tanya Cook, Nebraska Health and Human Services System, Omaha
Joyce Crawford, South Heartland District Health Department, Hastings
Vicki Duey, Four Corners Health Department, York
Cynthia Ellis, M.D., University of Nebraska Medical Center
Shinobu Watanabe-Galloway, Ph.D., University of Nebraska Medical Center
Terry Krohn, Two Rivers Public Health Department, Holdrege
John Linville, D.V.M., USDA Food Safety Inspection Service, Omaha
Sue Medinger, Nebraska Health and Human Services System, Lincoln
Cordelia Okoye, Ph.D., Lincoln-Lancaster Health Department, Lincoln
Becky Rayman, East Central District Health Department, Columbus
Josie Rodriguez, Nebraska Health and Human Services System, Lexington
Connie Schnoes, Ph.D., University of Nebraska-Lincoln, Lincoln
Wendy Wells, University of Nebraska Medical Center, Scottsbluff

The Great Plains Public Health Leadership Institute is an initiative of the Nebraska Educational Alliance for Public Health Impact (NEAPHI). It is supported in part by funding from the Center for Biopreparedness Education, Nebraska Health and Human Services System, Nebraska Health Care Cash Fund, the Robert Wood Johnson Foundation (Turning Point, Nebraska), the Upper Midwest Center for Public Health Preparedness, and the Upper Midwest Pubic Health Training Center. Additional in-kind support comes from UNMC, CityMatCH, and other NEAPHI member organizations.

Application deadline for the 2006-2007 year is June 16, 2006. □

Meth Action Web Site

The National Association of Counties (NACo) is committed to raising public awareness about, and helping counties respond to, the nation's methamphetamine drug epidemic. NACo has a ***Meth Action Clearinghouse*** on its Web site at:

http://www.naco.org/Template.cfm?Section=Meth_Action_Clearinghouse

A NACo Report, ***The Meth Epidemic in America,*** contains results from two surveys of U.S. Counties: "The Criminal Effect of Meth on Communities" and "The Impact of Meth on Children," available in PDF format at:

http://www.naco.org/Template.cfm?Section=Meth_Action_Clearinghouse&template=/ContentManagement/ContentDisplay.cfm&ContentID=17216

CAH *cont'd. from page 5*

ing staff and make corrections before there is a significant impact on the financial condition of the hospital. Currently, 11 CAHs have developed Balanced Scorecards, and 10 others are at the initial stages of the process. Within two years, more than half of the state's 65 CAHs are expected to be using a Balanced Scorecard.

Quality Improvement Efforts

Although the Balanced Scorecard process focuses on the overall performance of the hospital, the "FLEX" grant also provides funding for specific quality improvement efforts. The CAH Quality Improvement Steering Committee was formed in 2003 to coordinate these efforts. Since its formation, the committee has developed a Quality Improvement Manual and a QI Orientation Manual. Both of these manuals have been very helpful to new QI coordinators. The committee was also instrumental in designing a new Award of Excellence in Health Care Quality for CAHs and has organized several educational workshops on quality improvement topics.

Benchmarking Projects

Several quality improvement benchmarking projects are funded or monitored as part of the FLEX grant. These projects include the following.

- Funds have been used to support the use of the Clinical Outcomes Measurement System (COMS), a Web-based clinical benchmark system managed by the Nebraska Hospital Association. COMS acts as an "alert" or warning system that uses selected clinical outcome indicators such as length of stay, mortality rates, and readmission rates to monitor areas where a hospital's outcomes are significantly different from their peer group. Currently, 33 CAHs participate in the COMS system.
- Funds have been used to support the Multi-State Benchmarking Project. This project involves the states of Nebraska, Kansas, Michigan, and Montana. For the past year, six CAHs from Nebraska and 29 overall have reported data on 26 indicators to the Montana Hospital Association. In August, the project changed to a Web-based system under the leadership of the Kansas Hospital Association. After a six-month pilot test, additional hospitals from the four states and other states will be allowed to participate in the program.
- The FLEX grant provides funds based on the number of CAHs in a network. All of the major CAH networks have or are in the process of conducting benchmarking projects that involve all of the CAHs in the network. Many of the projects involve meeting the QIO standards on pneumonia or heart failure, as well as reducing medication errors. One network is also attempting to develop an electronic health record that links the network hospital with all of the CAHs in the network.
- The FLEX program tracks but does not fund the Voluntary CMS Hospital Quality Initiative Project. Currently, more than 30 CAHs are participating in this program, which involves meeting the QIO's quality standards for acute myocardial infarction, heart failure, and pneumonia.

Mentoring Program

The FLEX grant provides a small stipend to experienced QI coordinators who act as mentors for new QI coordinators. The mentor reviews the QI Orientation Manual with the new coordinator and acts as a resource person during the new coordinator's first year on the job.

Patient Satisfaction Surveys

Flex grant funds are used to fund more than 8,000 patient satisfaction surveys for 21 CAHs. The surveys enable CAHs to compare their progress in patient satisfaction with previous years, with other CAHs in the state, and eventually with hospitals across the nation. They are also an important measure used in the Balanced Scorecard.

Evidence-Based Quality Indicators

Some FLEX funds were used to print and distribute the Evidence-Based Quality Indicators Report. This report, developed by the Heartland Health Alliance and the Southeast Rural Physicians' Alliance, was sent to all CAHs to assist them in establishing guidelines for quality improvement in the following diagnoses: acute coronary syndrome, atrial fibrillation, heart failure, stroke, pneumonia, surgical site infection, C-section, and diabetes. For each quality indicator under these diagnoses, the acceptable standard is identified as well as additional considerations and the specific references. These indicators are also used by many physicians for medical peer review.

In conclusion, the Medicare Rural Hospital Flexibility Grant has funded several performance/quality improvement initiatives for critical access hospitals. These initiatives have provided new tools and information to assist small rural hospitals as they have begun to focus on improving their overall performance.

One of the lessons learned is that performance/quality improvement is multi-dimensional and that no single project can produce the desired results. A second lesson is that when CAHs work together in a network, they are more likely to share ideas and improve their overall results. Finally, for benchmarking projects, it is important to compare the results with those from a similar "peer" group. □

Rural Nebraskans *cont'd. from p. 7*

the Hotline can receive no-cost vouchers for confidential mental health services. More than one hundred mental health providers throughout Nebraska have signed an agreement to accept these vouchers as full payment for their services.

It is this type of collaboration and cooperation that defines Interchurch Ministries of Nebraska, the state's largest ecumenical organization. IMN began its ministries in 1971 for Christian communions to come together for worship, teaching, service, and common witness to the faith. IMN is actively engaged in the "life and work" dimensions of ecumenism. Witness to unity in Christ is given through a variety of programs besides the Farm Crisis Response Council and the Rural Response Hotline. Other IMN ministries include: the Nebraska Health Ministry Network, the Behavioral Health Project, Faith-Based Response to Domestic Violence, Grants to American Indians in Nebraska, the Peace with Justice projects, Disaster Response, Campus Ministries, Ecumenical Legislative Briefing Day, and the Community Gardens.

Denominations covenanting to express Christian unity through these ecumenical ministries include American Baptist Churches of Nebraska; Christian Church (Disciples of Christ) in Nebraska; Church of the Brethren, Western Plains District; Episcopal Diocese of Nebraska; Evangelical Covenant Church, Midwest Conference; Evangelical Lutheran Church in America; Presbytery of Central Nebraska; Homestead Presbytery; Presbytery of Missouri River Valley; United Church of Christ; and the United Methodist Church, Nebraska Conference.

For more information, call IMN – Marilyn Mecham at (402) 476-3391. □

Good faith was the major issue: a mediation story

By Marilynne Bergman, Farm Mediator

The day was cold but sunny. After a drive of 2½ hours, I arrived at the Mediation session location, a library with a private meeting space. I arranged the room to facilitate communication by removing some chairs from the table and set up my computer in preparation for writing an agreement. I checked with the librarian about printing and copying the agreement after approval and singing. All was in readiness for the participants' arrival.

The first to arrive and enter the room were the two men from the Farm Service Agency (FSA). We chitchatted about the weather and our respective trips to the library. The Farm family arrived right on time. I believe they had been waiting at a table in the library, having a quiet conversation.

After confirming their names, I introduced myself and started the session. I gave my usual opening remarks and asked for their opening statements. The farmer and his wife opened first because they had requested the mediation. They were well prepared, and it appeared that they had worked hard to get their position down on paper. They had farmed for over 20 years in the same location and had never had any adverse decision against them by FSA. They stated that they were respected members of the community.

Their issue was a finding of not in good faith by the FSA County Committee for the moving of loan grain from one location to another in preparation to feed the grain. The farmer had failed to notify the FSA office, and upon spot check by the FSA, a shortage was discovered in the bin. The farmer had met with the FSA County Committee that heard the case. He expressed concerns about some of the statements made during the meeting by the FSA and others at the table.

The FSA responded with their opening statement and spoke about telephone conversations and expectations. They also gave details of the definitions and terms they are required to abide by from their handbook. Some time was spent discussing the regulations, definitions, and general provisions required when dealing with producer violations. A considerable discussion of the good faith determination was held, with all parties expressing their thoughts and opinions.

Discussion continued concerning the issue of the FSA loan grain having been moved to another location without prior notification to the FSA. Discussion also centered around the trust and confidence issues of the farmer and his wife. It was determined that good faith was the major issue, and the FSA agreed to return to the County Committee to further explore that issue of this case, and the finding of not in good faith in particular. The farm family agreed that they would like that reconsideration to happen.

I questioned both parties regarding their commitment to a future relationship. The farmer committed to abide by all FSA requirements concerning grain on loan in the future, and the FSA men seemed happy with that commitment. The farmer particularly agreed to communicate with the FSA before he moved any loan grain from sealed bins. The FSA men agreed to consult the appropriate FSA officials to obtain concurrence about the County Committee reconsideration and to proceed with the reconsideration if all agreed.

I wrote the agreement made by the parties, and they reviewed and modified it. The agreement was signed, and the parties left. I do not believe all of the wounds of the dispute relating to personalities and feelings were totally mended, but I believe a start was made.

For help call the Farm Hotline: (800) 464-0258 □

2006 Nebraska Rural Health Conference

By Cindy Evert-Christ

The 2006 conference, entitled "The Transformation of Rural Healthcare" is on the drawing board with several national speakers addressing the cultural changes taking place in rural health.

Speakers include:

- **Mary Wakefield** - How to Develop a Community Health Model in Rural Areas
- **Jon White** – AHRQ: What HIT Models Are Teaching Us
- The Mental Health Evolution in Nebraska
- A Balanced Score Card Update and Impact
- Telehealth: The Nebraska Network Model/Impacts
- EMS: Changing the Way We Perceive Emergency Care
- Medicaid: The Issue and the Direction
- Registry Project: Rural Health Clinics' Use of Electronic Tools for Care

The Nebraska Rural Health Association (NeRHA) is committed to providing leadership on these rural health issues through advocacy, communication, and education. The NeRHA's annual conference provides a forum to address rural health concerns and to develop and promote effective solutions at the local, state and national levels.

Mark these dates on your calendar — **September 7 and 8, 2006** — and see for yourself how good the topics and food are at this conference. Watch for more information in future additions of Access and on the NeRHA Website at www.nebraskaruralhealth.org. For additional information, contact the conference planner at nerhaconf@alltel.net. □

MARK YOUR CALENDARS

Rural Health Advisory Commission Meeting
February 24, 2006 - 1:30 p.m.
State Office Building, Lincoln, NE

National Rural Health Association Policy Institute
February 27-March 1, 2006
Washington, DC

2006 Nebraska Family Health Conference
April 18-19, 2006
Holiday Inn, Kearney, NE

Annual National Rural Health Association Conference
May 16-19, 2006 - Reno, Nevada

Certified Rural Health Clinics Billing/Coding Workshops
September 5-6, 2006 (tentative)
Holiday Inn, Kearney, NE

Annual Nebraska Rural Health Conference
September 7-8, 2006
Holiday Inn, Kearney, NE

Annual Minority Health Conference
October 31 - November 1, 2006
Holiday Inn, Kearney, NE

Nebraska Telehealth Network Conference
May 22 OR 23, 2006
Call (402) 471-0142 for site info

New resources available

Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series -- Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders; 600 pages (approximately), 6 x 9, 2006. From the Institute of Medicine (IOM), available online at http://www.iom.edu/CMS/3809/19405/30836.aspx
Millions of Americans today receive health care for mental or substance-use problems and illnesses. These conditions are the leading cause of combined disability and death of women and the second-highest of men.
This new IOM report addresses issues pertaining to health care for both mental and substance-use conditions and the essential role that health care for both plays in improving overall health and health care. In doing so, it details the actions required to achieve those ends – actions required of clinicians; health care organizations; health plans purchasers; state, local, and federal governments; and all parties involved in health care for mental and substance-use conditions.

Connecting America's Rural Areas to Broadband
Oct 20, 2005 -- The Hill, (DC). This article discusses how high-speed broadband Internet can bring rural America into the 21st century by allowing rural businesses to connect with the rest of the world, allowing schools to utilize information and resources, and hospitals to serve patients better. Available at http://www.thehill.com/thehill/export/TheHill/News/Frontpage/102005/ssudall.html. (Notice the mention of the need for rural hospitals to have access to broadband!)

ACCESSory Thoughts

Dennis Berens, director
Nebraska Office of Rural Health

Information - Knowledge

Phase 1 is almost finished. As you read this column, the final steps/testing are being done on the Nebraska Telehealth Network. This issue of ACCESS includes several stories about the Network and the related efforts to use this tool. Congratulations to the many wonderful partners who nurtured this model along the way.

So what's next for the 88 hospital communities, the publics health departments, and all who connect to this new telecommunications system?

I think our next challenge is to turn this new ability to move information -- lots of information -- into knowledge that can be used to help health care professionals care for us and our communities. Instead of wasting time searching for information, we can all focus more on assessing the information's worth and source. We can now send an X-ray instantly from a rural hospital to a medical center. We can move a possible public heath incident or threat to a state lab, instantly. We can begin to think about searching huge data banks, finding specific health information, and using that information with our diagnosis. We can then have a video connection to an appropriate provider to help us understand the best possible next steps to regain our health.

The possibilities are endless, but the process to accomplish this must be simple if we are to fully take advantage of this technology.

Here are a few steps that could ease this process:

1. Health care professionals should immediately try this new technology. Experiment with it, find its pluses and minuses, and suggest Phase 2 model changes.
2. Health care consumers should immediately go to their hospitals or public health departments to learn about this new technology and its potential.
3. Health care administrators should utilize this equipment for their administrative and training needs. They must understand the system to understand what the professionals and consumers see as the advantages and disadvantages.
4. Policy makers must also go and see this system and ask questions to understand the present and future policy issues that will have to be addressed (e.g., regulation and licensure).

Underlying these four suggestions is communication. Telecommunications has made communication faster and also more far removed. We need to have household to household, community to community, and state to state discussion about how to turn all this information into knowledge — knowledge that can enhance our quality of life and knowledge that can link our health resources to serve the 1.7 million people who call themselves Nebraskans.

May 2006 be the year that we start this process. □

ACCESS
Office of Rural Health
Nebraska Health and Human Services System
Department of Regulation and Licensure
P.O. Box 95007
Lincoln, NE 68509-5007
(402)471-2337

Address Service Requested

PRSRT STD
U.S. POSTAGE
PAID
PERMIT NO. 212
LINCOLN, NE

20-17-00